# REGISTERED NURSES' REGISTRATION FORM

To register with Flax Healthcare please ensure that you have at least six months of employment /work experience in the UK care industry and are able to provide us with two contactable referees (including one clinical reference ) with full contact details including email, postal address and telephone number.

**It is mandatory requirement to complete all sections of this form. Please ensure you answer ALL questions on this form * Send us all required documents * Use black ink pen**

## A. YOUR PERSONAL DETAILS

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (Please State)

Surname: First Name(s):

Address:

Post code:

Daytime phone number: Mobile:

E-mail address:

Nationality Do have use of you own car / Drive? Yes ☐ No ☐

Do you hold a current full UK driving license: Yes ☐ No ☐

## B. YOUR PROFESSIONAL NURSING REGISTRATION DETAILS

HCPC / NMC PIN: Expiry Date: / /

Union Name: Membership Number:

Revalidation Date: Date of your last appraisal:

Qualifications:

## C. YOUR ELIGIBILITY TO WORK / PASSPORT DETAILS

Eligibility to work in the UK YES ☐ NO ☐

I am eligible to work in the UK and do not require a work permit ☐

I have a work permit to work in the UK ☐

I need a work permit to work in the UK ☐

If other please specify:

National Insurance Number:

Passport Number: Work Permit / Visa Number:

Work Permit / Visa Expiry:

## D. YOUR EMPLOYMENT & VOLUNTEERING HISTORY

| DATE FROM MM/YY | DATE TO MM/YY | EMPLOYER'S NAME AND ADDRESS | POSITION AND PRINCIPAL DUTIES | REASON FOR LEAVING |
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Please confirm that you have supplied a copy of your CV giving full employment details, covering a minimum of 10 years or back to your Qualification as a Registered Nurse. Explain all employment gaps up till date on a separate sheet of paper if necessary.

Comprehensive CV attached (Optional) ☐

## E. EDUCATION AND RELEVANT TRAINING

| NAME OF SCHOOL / COLLEGE / UNIVERSITY | DATES OF TRAINING / ATTENDANCE | QUALIFICATIONS OBTAINED |
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RELEVANT POST REGISTRATION / MANDATORY TRAINING

| NAME OF COURSE OR STUDY | OBTAINED | EXPIRES | TRAINING PROVIDER |
|---|---|---|---|
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## F. CLINICAL EXPERIENCE

Please tick the boxes with which you have expertise in:

| | | | |
|---|---|---|---|
| A&E ☐ | Cardiac ☐ | Clinics ☐ | Community ☐ |
| Diagnostic Imaging X-ray ☐ | Elderly Care ☐ | Endoscopy ☐ | General Wards ☐ |
| Gynaecology ☐ | HDU ☐ | Health Visitor ☐ | Home Care ☐ |
| ITU ☐ | Learning Disabilities ☐ | Medical ☐ | Mental Health ☐ |
| Midwifery ☐ | Neonatal ☐ | NICU ☐ | Nurse Practitioner ☐ |
| Nursing Homes ☐ | Occupational Health ☐ | ODP ☐ | Oncology ☐ |
| Chemotherapy ☐ | Orthopaedics ☐ | Paediatric A&E ☐ | Paediatrics ☐ |
| Palliative ☐ | PICU ☐ | Practice Nurse ☐ | Prison ☐ |
| Radiology ☐ | Recovery ☐ | Renal ☐ | Dialysis ☐ |
| SCBU ☐ | Surgical ☐ | Theatre ☐ | Triage ☐ |
| Urology ☐ | Walk in Centre ☐ | Other ☐ | |

Please be specific if you ticked other:

## G. DECLARATIONS

PROFESSIONAL CONDUCT

Has there been any proceedings of medical negligence or professional misconduct against you?

☐ Yes ☐ No

Have you ever been suspended or dismissed? ☐ Yes ☐ No

If "Yes" please provide details:

REHABILITATION OF OFFENDERS ACT

The position you are applying for (whether paid or voluntary) is listed in Schedule 1, Part II of the Rehabilitation of Offenders Act (Exceptions) Order 1975, so we are entitled to ask Exempted Questions as defined by Section 113(5) of The Police Act 1997 about you.

The nature of the work placements offered by us means the terms of Section 4 part 2 of the Rehabilitation of Offenders act (1974) (exceptions) Order 1975, apply. You must declare here any convictions or cautions you have ever received, even those which would normally be considered spent.

Have you got any unspent conviction either criminal or civil? YES ☐ NO ☐

If yes, please give details:

## H. YOUR NEXT OF KIN / EMERGENCY CONTACT DETAILS

1. Name:

Relationship to you:

Address:

Postcode:

Contact Phone Number:

2. Name:

Relationship to you:

Address:

Postcode:

Contact Phone Number:

## I. YOUR REFERENCE DETAILS

- Please supply the names and work addresses of at least 2 clinical professional references.
- One must be from your present or most recent employer and must be a senior grade than yourself.
- You must have worked for that person for a period of more than 3 months to present.

CLINICAL REFERENCE 1

Name: Position:

Address:

Postcode:

Daytime Phone Number: Other Phone Number:

Email address:

What was your professional relationship with this person?

Date: From: / To: /

I. YOUR REFERENCE DETAILS (Cont)

CLINICAL REFERENCE 2

Name: Position:

Address:

Postcode:

Daytime Phone Number: Other Phone Number:

Email address:

What was your professional relationship with this person?

Date: From: / To: /

I hereby give permission for my referees to be contacted and for my references to be shared with third parties if necessary. Yes ☐

**DBS REFERENCE**

If you have a **current or valid CRB or DBS Certificate** or are on the **DBS UPDATE SERVICE**, provide your

**DBS Reference Number:**

## J. WORKING TIME REGULATIONS

I wish to work for 48 hours or more a week ☐

I do not wish to work for hours in excess of 48 hours a week ☐

I understand I may withdraw this consent by giving Flax Healthcare not less than 3-months' notice. ☐

## K. YOUR BANK ACCOUNT DETAILS

Please tick A, B **or** C as applicable to you

**A.** I wish to be paid through an Umbrella Company of my choice and enclose details. ☐

Umbrella Company Name:

Umbrella Company email: Phone Number:

*(You will be paid as P.A.Y.E until you provide all your documents to Flax Healthcare)*

**B.** I am on P.A.Y.E ☐

*(Please enclose a P45 Form if we are your main employer)*

**C.** I have got my own Limited Company ☐

*(IF YOU HAVE YOUR OWN LTD COMPANY, you MUST provide a copy of your Certificate of Incorporation, Company Bank details and proof of Indemnity Insurance. We can NOT make payments into a personal Bank Account.)*

Account Holder / Business Account Name:

Name of Bank: Branch Name:

Sort Code: Account Number:

Branch Address: Postcode:

Please note that we will pay you weekly in arrears into your nominated account.

**I confirm that the information I have given in this application, is to the best of my knowledge, true. I am permitted to work in the UK. I understand that my registration is subject to the receipt of at least two satisfactory references and an enhanced disclosure from the Disclosure and Barring Service (DBS). I undertake to inform Flax Healthcare Limited should I be convicted of an offence in the future. I undertake to inform Flax Healthcare immediately if I am engaged through their introduction, including the offer of permanent employment following a temporary assignment. I agree to respect the confidentiality of patients and any other information I may have access to, at all times. I am clear that Flax Healthcare cannot guarantee assignments and that they have no responsibility to pay for hours not worked, no matter the situation.**

**I confirm that I have been given a copy of the Staff Handbook and I confirm that I have read, understand and agree to the Terms & Conditions and the Code of Conduct set by Flax Healthcare.**

Signed: _____ Date: _____